2022 Participant Application

Legal Name: _____DOB: _____

Mailing Address: _____
Street address City
State Zip
Phone: _____ Email:_____
Cell Work
School/Group: _____ Grade: _____
Weight: _____ Height: _____ Shoe Size: _____
Responsible party for Trotting Horse fees: _____
Medicaid Waiver Info: _____
Case Worker: _____Phone:_____
Does THTR and/or Back Office Solutions have permission to contact your case worker for billing purposes? YES____ NO _____

Note: THTR is covered under Montana Medicaid Community & Home Based Services. In order for our services to be covered by Medicaid, clients are required to be enrolled in a participating Medicaid Waiver program and have a case worker with the ability to provide a Prior Authorization Referral for services. ANY and ALL charges not covered by Medicaid will be billed and due by the client or guardian.

Emergency Information – Required Please furnish the name and phone # of a contact person (if under 18, in addition to parent)		
Name:		Relationship:
Address:		
Home Phone:	Cell:	Work:
Physician Name:		Phone:

PARENT/GUARDIAN INFORMATION, IF UNDER 18

Parents/Legal Guardian: _____ Phone: _____
Mailing Address _____
Street City State Zip
Mother's Email: _____ Alternate Phone: _____
Father's Email: _____ Alternate Phone: _____

Trotting Horse Therapeutic Riding

Does your child have an IEP? A copy of your child's IEP/BIP can be a great tool for success/safety!
___ Yes, I will provide a copy of my child's IEP/BIP to Trotting Horse Therapeutic
___ No, I will not provide a copy of my child's IEP/BIP

X _____

Parent/Guardian Signature **Printed Name** **Date**

Please list the people who have permission to pick up your child.

1. Name: _____ Phone: _____

2. Name: _____ Phone: _____

3. Name: _____ Phone: _____

- I agree to respect Trotting Horse Therapeutic participant, staff and volunteer rights with regard to privacy of information and to keep "professional" confidentiality in all my statements both within and outside of the organization.
- I understand Trotting Horse Therapeutic staff members have the authority to exclude participants from the program for behavior they deem to be unsafe. Use of drugs/alcohol is unsafe behavior.
- I give my consent to Trotting Horse Therapeutic to obtain medical care from any licensed physician, hospital, or clinic for any injury that could arise from participation in Trotting Horse Therapeutic activities.

X _____

Signature of Participant or Guardian **Date**

DISABILTY & MEDICAL INFORMATION: Please fill out thoroughly and legibly. We must have this information to provide a safe program. *Participant name:* _____
Please circle choices that apply.

Participant's Disability _____ Date of Onset _____
Explain Type/Level_____
Secondary Disability? _____

Wheelchair use? Electric Manual No If yes, % of time _____ Assistance? _____

What aide, if any is needed to walk? (walker, brace, cane, etc.) _____

Subject to seizures? Yes No Type _____ Frequency _____
Date of most recent seizure? _____ Seizure medication _____

Current Medications;_____

Allergies?_____

Visual or hearing impairment? Yes No If yes, please describe: _____

Communication style? Verbal Nonverbal Sign Other: _____

Currently receiving treatment or therapy? Physical Occupational Mental Health Other
Please describe: _____

Any injuries, surgeries, illnesses or skin breakdown in the last year? Yes No If Yes, please describe: _____

Any body parts susceptible to cold, heat, impact? Yes No If Yes, please explain:_____
_____

How does participant behave when upset or frustrated? History of physical aggression? _____
_____

What are participant's special interests, like, or motivators? (e.g. music, talking about sports, etc.) ___
_____

Any fears or concerns? _____

What goal will be achieved while at Trotting Horse Therapeutic? _____
_____

Which of the following barriers restrict physical activity? Please circle all that apply.

Lack of endurance Lack of coordination Lack of mobility Lack of flexibility
Low/high muscle tone Muscle spasticity Other: _____
_____

THANK YOU FOR PARTICIPATING WITH THTR

It is the responsibility of the participants. Parents and guardians to notify THTR if any of the above information changes during the year the application is in effect.